WESTSIDE
PAIN MANAGEMENT

Patient Financial Responsibility Consent

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policies. If you have any questions about the policy, please discuss them with a member of our management team. Please understand that payment is expected for services rendered. Please read, sign and date the agreement prior to treatment.

I understand and agree that I will be financially responsible for any and all charges for services rendered if not paid by my insurance. This includes any medical service, Injections and any other services performed by physician or physician staff.

- I understand and agree that it is my responsibility and not the responsibility of the physician or staff to know if my insurance will pay for such medical services that includes injections, office visits and surgeries.
- I understand that it is my responsibility to know if my insurance is out of network, has any deductible, Copayment, Co-insurance, and or unusual and customer a limit or any other type of benefit limitations for the service I receive.
- I understand that it is my responsibility to know if the medical care professional and /or physician I am saying is contracted in network provider recognized by my insurance company or plan.
- **___(Initials)**
- If the physician I am seeing is not a contracted in-network provider, it may result in claims being denied or higher out of pocket expense for me and I understand this and agree to be financially responsible and make full payment at Self Pay Services rates. **___(Initials)**

I understand that in the event, that my insurance is not valid, or my coverage was terminated at the time the services are rendered, I will be responsible for the full amount at Self Pay rates of my office visit and or any procedures rendered. Additionally, I understand that certain medical appointments with certain diagnosis can trigger a medical necessity or more depending on services rendered by the physician or physician staff. I understand that if my insurance rejects or denies their monetary responsibility to medical necessity that I am responsible for payments of the Self Pay rates. **____ (Initials)**

Or Additionally, I understand that certain medical appointments with certain diagnosis can trigger a medical necessity or more depending on services rendered by the physician or physician staff. I understand that due to the historic denials by Insurances like mine, Physician's office will collect the payments at Self Pay rates at the time of visit. **___ (Initials)**
I fully understand should my account become delinquent, can be subject to further action like collections.

For your convenience, or practice accepts Visa, MasterCard, Discover, and Cash

I have read and agree to the above financial responsibility.

_____
Signature
_____
Name
_____
Date

PATIENT FINANCIAL STATEMENT OF INFORMATION

Thank you for choosing Westside Pain Management as your pain provider. All providers are committed to providing patients with the utmost quality of care and innovative pain management services.

Due to differences in each patients' insurance policy and coverage, we have developed this payment policy regarding patients and their insurance responsibility for services rendered by our practice. Please read it, ask us any questions you may have, and sign in the space provided below. A copy will be provided to you upon request.

Insurance and Billing

- As your provider, please remember that our relationship is with you and not your insurance company. Your benefit coverage is a contract between you and your insurance carrier. Please be aware that not all medical services are covered benefits under all insurance contracts.
- We encourage you to be familiar with your insurance benefits and limitations. If you have any questions about your insurance coverage, please contact your insurance carrier directly.
- All doctors are Preferred Provider or many insurance plans. It is your responsibility to check with your insurance carrier to ensure that we participate in your insurance network.
- As a service to you, our office will bill your health insurance company. Providing us with the accurate information at the time services are rendered will facilitate in the timely filing of claims. Changes in your information should be reported to our office In a timely manner. Your cooperation in keeping your account Information current is greatly appreciated.

Co-payments, Co-insurance, and Deductibles

All copayments, coinsurance, and deductibles are due at the time of service.

- **Co-payments** are a flat fee paid each time a medical service is accessed and must be paid before any policy benefit is payable by an insurance company. Copayments differ depending on your insurance coverage.
- **Co-Insurance** is a percentage of the allowed charge that the patient pays after the deductible has been met.
- **Deductibles** are amounts which must be paid out-of-pocket before an Insurance carrier will pay any expenses. The deductible must be paid by the patient before the benefits of the insurance policy can apply.

Westside Pain Management INC including the providers within the clinic, is in-network with most insurance companies and the insurance company will require that we collect these fees per the terms of your health care contract. Failure to pay any amounts due, including past due balances, will result in your appointment being rescheduled or other collection activity.

For your convenience, we accept cash, checks, debit or credit cards (MasterCard, Visa, Discover, American Express.) A fee of $35.00 will be charged for all returned checks.

Self-Pay

If you are uninsured and are in need of care, we can see you on a self-pay basis and payment is due at the time services are rendered.

Referrals/Authorizations

Many of the services we provide require referrals, authorizations, and pre-authorizations. Your insurance company may require documentation prior to authorizing services and we will do our best to comply in a timely fashion with their requests. This process can take time and we appreciate your patience while we work with your insurance company to obtain approval. We reserve the right to refuse or reschedule services to any patient who does not have a valid referral in our office at the time ***of*** their appointment.

I have read and understand the above financial responsibility policy.

I hereby authorize Westside Pain Management to file claims on my behalf and for payment to be rendered directly to Westside Pain Management for benefits otherwise payable to me by any third party. If my insurance does not cover services rendered, I agree to be personally and fully responsible for payment. The above authorization is in effect permanently or until canceled by myself in writing.

Patient Signature: _____ **Date:** _____

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ACKNOWLEDGEMENT OF CONTROLLED SUBSTANCE PRESCRIPTION USE

This agreement between _____ (the patient) and Westside Pain Management, Inc. (the physician) is for the purpose of establishing an agreement between the doctor and patient on clear conditions that the patient agrees to in order to receive pain management and/or pain medication(s). This may include the care from multiple disciplines, including diagnostic and/or therapeutic interventions, behavioral medicine (psychology, psychiatry, coping strategies, biofeedback), alternative therapies, physical therapy, weight management, and the prescription use of medications. The doctor and patient understand that this agreement is an essential factor in maintain the trust and confidence necessary in a doctor/patient relationship. Pain medication may not completely eliminate your pain, but is expected to reduce it enough that you may become more functional and improve your quality of life.

Your initials are required next to each of the following statement in the space provided.

I agree to and accept the following conditions for my pain management:

__ 1. I understand that strong medications, which may include opioids and other controlled substances, may be prescribed for pain relief, if my physician determines it would be of benefit. I understand that there are potential risks and side effected involved with taking any medications, including the risk of addiction. Overdose of opioid medication may cause injury or death. Other possible complications include, but are not limited to, constipation, which could be severe enough to require medical treatment, difficulty with urination, fatigue, drowsiness, nausea, itching, stomach cramps, loss of appetite, confusion, sweating, flushing, depressed respiration, and reduced sexual function. Men may have decreased testosterone from chronic opioids.

__ 2. I understand that it is my responsibility to keep others and myself from harm. This includes the safety of my driving and the operation of machinery. If there is any question of impairment of my ability to safely perform any activity, I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have stopped the medication long enough for the side effects to resolve. This applies to all medications prescribed to me. Prescriptions and bottles of medications must be safeguarded from loss and out of reach of children.

__ 3. I realize that all medications have potential side effects and interactions. I will inform the office of any adverse effects I am experiencing when they are of a nature to cause me concern. I understand and accept that there may be unknown risks associated with the long-term use of the substances prescribed.

__ 4. I understand that if I am pregnant or become pregnant while taking medications, my child could be physically dependent on the opioids and withdrawal can be life threatening for a baby. If a female of child bearing age, l certify that *I* am not pregnant, and I will use the appropriate contraceptive measures during the course of treatment, with medications. Many medications could harm the fetus or cause birth defects.

__ 5. I understand I must contact my physician before taking newly prescribed tranquilizers or prescription sleeping medications. I understand that the combined use of various drugs, opioids, as well as alcohol, may produce confusion, profound sedation, respiratory depression, blood pressure decrease, and even death.

__ 6. I understand that opioid analgesics could cause physical dependence within a few weeks of starting opioid therapy. If *I* suddenly stop or decrease the medication, I could have withdrawal symptoms (including nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-48 hours of the last dose.

ACKNOWLEDGEMENT OF CONTROLLED SUBSTANCE PRESCRIPTION USE

__ 7. Withdrawal from other medications can also have serious consequences, including the risks of injury or death. I will not discontinue any medication I take regularly without consulting my physician.

__ 8. I agree that continued treatment and/or refill of medication(s) may be contingent upon compliance with other pain treatment modalities recommended by my doctor.

__ 9. I am responsible for keeping my scheduled appointment. Prescription renewals are contingent upon keeping each scheduled appointment. Requests for refills of medications due to rescheduled or missed appointments are prohibited, except in emergency circumstances as determined by and at the Physician's discretion and will only be bridged until the next available appointment.

- Refill request for medication requiring a written prescription must be called to the office 48 business hours prior to pick up. Written prescriptions must be picked up at the office. Written prescriptions will not be mailed or delivered by any other manner.
- Refills will not be made if I "run out early" or "misplace my medication" or if someone else has been taking some of my prescription. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
- Refills will only be made for a lost or stolen prescription if a police report has been filed.

__ I 0. I agree that I will use my medication at a rate no greater than the prescribed amount unless it is discussed directly with my physician. I understand I can be asked to bring any or all of my prescribed medications to my office appointment or at a random time for a prescription compliance check (Pill Count).

__ 11. I will not use any illegal substances (cocaine, heroin, marijuana, etc.) while being treated with controlled substances. Violation of this will result in the cessation of the prescribing of any controlled substances and termination of my care.

__ I 2. I will not share, sell, or trade my medication or exchange medication for money, goods, or services.

__ 13. 1 understand that changing dates, quantity, or strengths of medication or altering a prescription in any way is against the law. Forging prescriptions or physician's signature is also against the law. Our office cooperates fully with the law enforcement agencies in regards to infraction involving prescription medications.

__ 14. I will discontinue all previously used pain medication, unless told to continue them by my physician. I will keep this office informed of all medications I may receive from other physicians.

_ 15. I agree that I will submit to random urine, blood, saliva toxicology test if requested to determine my compliance with this agreement and my regimen of pain control medication. Tests may include screens for illegal substances.

- I understand that I will be financially responsible for the charges for any urine, blood, or saliva test.
- I understand that I will be financially responsible for the charges for any urine, blood, or saliva test that has to be sent out to an outside lab for testing or confirmation.
- Presence of unauthorized substances or the lack of prescribed medications may necessitate a referral to an addiction specialist, as well as, dismissal from this practice.

ACKNOWLEDGEMENT OF CONTROLLED SUBSTANCE PRESCRIPTION USE

__ 16. I will not attempt to get pain medication from any other health care provider without telling them that I am already taking pain medication prescribed by this office.

__ 17. I understand that my medication regimen may be continued for a definitive time period as determined by my physician. My case will be reviewed periodically. lf there is not significant evidence that I am improving or that progress is being made to improve my functioning or quality of life, the regimen might be tapered or possibly discontinued and my care referred back to my primary care physician.

__ 18. Jwill keep all scheduled follow-up appointments as outlined in my treatment plan.

__ 19. I understand that the main treatment goal using pain medications is to improve my ability to function and/or to work and/or to reduce pain. In consideration of that goal, and the fact that I may be given potent medication to help me reach that goal, I agree to help myself by following better health habits. This may include exercise, weight control, and avoiding the use of nicotine. I must comply with the treatment plan as prescribed by my doctor.

__ 20. I authorize my physician to provide a copy of this agreement to my pharmacy, other healthcare providers, and any emergency department upon request. I give my permission to allow sharing of medical history in regards to medication use with other health care agencies.

__ 21. I agree that this agreement is important to my doctor's ability to treat my pain effectively and that my failure to comply with the agreement may result in the discontinuation of prescribed medication by my doctor and termination of the doctor/patient relationship.

I have thoroughly read, understand, and accept all of the above provisions. Any questions I had regarding this agreement have been answered to my satisfaction. I understand all the policies regarding the prescribing and use of opioids and other medications. I agree to comply with the pain management program. I also agree to testing physiological, toxicology, and/or psychological and detoxification if indicated.

Your physician understands that emergencies can occur and under some circumstances, exceptions to these guidelines may be made. Emergencies will be considered on an individual basis.

Lack ofstrict adherence lo any provision ofthis agreement by your physician in no way invalidates any other provisions ofthis agreement.

Patient Signature _____ **Date** _____

Witness: _____ **Date** _____

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NEW PATIENT INFORMATION FORM

PATIENT INFORMATION

Last Name:	First:	Middle:	☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss	Marital Status (circle) Sin / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Date of Birth: i.e. MM/DD/YYYY ____ / ____ / _____	Age:	Sex: ☐ Female ☐ Male

Social Security #: _____ -- _____ -- _____	Email Address:	Home Phone #: ( ) --

Street Address:	City:	State:	Zip Code:	Cell Phone #: ( ) --

Preferred Method of Contact: (circle) Email / Cell / Home / Work	Occupation:	Employer:	Employer Phone #:

Referred to office by (Please check one box):
☐ Dr._____ ☐ Family ☐ Friend ☐ Yellow Pages ☐ Insurance Plan ☐ Adjuster ☐ Hospital ☐ Website _____ ☐ Other _____

Referring Physician's Name:	Address:	Telephone #: ( ) --
Primary Care Physician's Name	Address:	Telephone #: ( ) --

INSURANCE INFORMATION

Primary Insurance:			Address:		
Subscriber's Name	Subscriber's SS #:	Date of Birth: ____ / ___ / ____	Policy/Claim #:	Group #:	Co-Payment:
Relationship to Subscriber:	☐ Self	☐ Spouse	☐ Child		☐ Other:

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NEW PATIENT INFORMATION FORM

Secondary Insurance:			Address:		
Subscriber's Name	Subscriber's SS #:	Date of Birth: ____/____/____	Policy/Claim #:	Group #:	Co-Payment:
Relationship to Subscriber:	☐ Self	☐ Spouse	☐ Child		☐ Other:
Is injury related to ____ Work _____ Auto Accident? If yes, please fill out below (where applicable)					
Auto Accident Claim #:		Attorney's Name:		Address:	
Email:		Telephone:		Fax:	
Workers' Compensation Claim #		Adjuster's Name		Address:	
Email:		Telephone:		Fax:	

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at the same address):	Relationship to patient:	Home Phone #: ( ) --	Work Phone #: ( ) --

PREFERRED PHARMACY			
Pharmacy's Name	Address:	Telephone: ( ) --	Fax: ( ) --

AUTHORIZATION & ASSIGNMENT OF BENEFITS: The above information is true to the best of my knowledge, I authorize my insurance benefits to be paid directly to Westside Pain Management, Inc. I understand that I am financially responsible for any co-payments, deductibles, or uncovered amounts. I also authorize Westside Pain Management, Inc. or insurance company to release any information required to process my claims. I consent to the performance of examinations and diagnostic procedures my physician considers to be medically necessary. I authorize Westside Pain Management, Inc. to disclose health information necessary to process claims related to my care and to other health care providers for continuing care and treatment. I have received a Notice of Privacy Practices and have been provided an opportunity to request restrictions to the use and disclosure of my health information.

Patient's Name:	
Patient's Signature:	Date: _____/_____/_____

MEDICAL HEALTH QUESTIONNAIRE

PAST MEDICAL HISTORY

Please check all that apply

☐ AIDS/HIV	☐ Aneurysm	☐ Arthritis	☐ Asthma
☐ Bleeding Disorder	☐ Cancer	☐ Chem. Dependency	☐ CA Colon
☐ CA Lung	☐ CA Breast	☐ CA Prostate	☐ CA Cervical
☐ COPD	☐ Depression	☐ Diabetes	☐ Fibromyalgia
☐ Heart Attack	☐ Heart Disease	☐ Hepatitis	☐ Hypercholesterolemia
☐ Hypertension	☐ Hypothyroidism	☐ Jaundice	☐ Kidney Disease
☐ Liver Disease	☐ Murmur	☐ Osteoarthritis	☐ Pacemaker
☐ Peptic Ulcer Disease	☐ Peripheral Neuropathy	☐ Peripheral Vascular	☐ Post/-op Nausea/Vomit
☐ Acid Reflux	☐ Rheumatic Fever	☐ Seizure Disorder	☐ Sleep Apnea
☐ Stroke	☐ Other (please list):		

PAST SURGICAL HISTORY

List all previous surgeries:

DATE (MM/YYYY)	PROCEDURE

FAMILY HISTORY

Check if any of your BLOOD relatives have had any of the following:

DISEASE	RELATIONSHIP TO YOU
Asthma	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease (Stroke)	
High Blood Pressure	
Kidney Disease	
Neurologic Condition	
Bleeding Disorder	
Other (please list):	

SOCIAL HISTORY

Please check all that apply

Smoker Status (Meaningful Use)

☐ Current every day smoker ☐ Occasional Smoker ☐ Former Smoker

☐ Never smoked

Do you drink alcohol? ☐ Yes ☐ No ☐ Former

MEDICAL HEALTH QUESTIONNAIRE

How frequently do you drink alcohol?

☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Occasionally ☐ Rarely ☐ Socially ☐ Never

Do you use recreational drugs?

☐ Yes ☐ No ☐ Former
☐ Never ☐ Rarely ☐ Occasionally ☐ Often

What: _____ *How often:* _____

Exercise?

☐ Never ☐ Rarely ☐ Occasionally ☐ Often ☐ 2-3 times/ week ☐ 3-4 times/week ☐ Daily

ALLERGIES

Allergy	Reaction

MEDICATION HISTORY

Please list pharmacy if it differs from your preferred pharmacy with our office.

Medication Name	Dose	Frequency	Pharmacy

Have you taken any medications in the past for your current pain problem, even if they didn't work?
If yes, please list (be sure to include non-prescription medications such as Tylenol, topical analgesic cream, etc.)

NAME	WHY STOPPED

I, the undersigned, have completed this form to the best of my knowledge. The information that I have provided is true and accurate to the best of my knowledge. I understand that this information is used in the care and treatment plan while under the care of Dr. Arash Esmailzadegan and Westside Pain Management, Inc.

Patient's Name _____ Patient's Signature _____ Date _____

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REVIEW OF SYSTEMS

Patient's Name:	DOB:

Please review the following list and check any that apply to you. Please start with the left panel and move downward

CONSTITUTIONAL

- ☐ fever
- ☐ night sweats
- ☐ chills
- ☐ cold intolerance
- ☐ fatigue
- ☐ daytime somnolence
- ☐ weight gain
- ☐ weight loss
- ☐ polydipsia
- ☐ anorexia
- ☐ other:

EYES

- ☐ change in vision
- ☐ loss of vision
- ☐ blurred vision
- ☐ diplopia
- ☐ eye redness
- ☐ eye pain
- ☐ tearing
- ☐ purulent discharge
- ☐ other:

EARS

- ☐ difficulty hearing
- ☐ hearing loss
- ☐ ear pain/ear ache
- ☐ ear drainage
- ☐ tinnitus
- ☐ other:

NOSE

- ☐ nasal congestion
- ☐ nasal discharge
- ☐ epistasis
- ☐ sneezing
- ☐ snoring
- ☐ other:

MOUTH/THROAT/VOICE

- ☐ lip sores
- ☐ mouth sores
- ☐ tongue sores
- ☐ sore throat
- ☐ dysphagia
- ☐ odynophagia
- ☐ gum bleeding
- ☐ dental problems
- ☐ hoarse voice
- ☐ change in voice quality
- ☐ other:

NECK

- ☐ neck pain
- ☐ neck stiffness
- ☐ neck lumps
- ☐ neck swelling
- ☐ other:

RESPIRATORY

- ☐ dyspnea
- ☐ cough
- ☐ cough productive of sputum
- ☐ hemoptysis
- ☐ wheezing
- ☐ other:

CARDIOVASCULAR

- ☐ chest pain
- ☐ palpitations
- ☐ dyspnea at rest
- ☐ dyspnea with activity
- ☐ orthopnea
- ☐ paroxysmal nocturnal dyspnea
- ☐ lower extremity edema
- ☐ varicosities
- ☐ other:

REVIEW OF SYSTEMS

GASTROINTESTINAL
- ☐ abdominal pain
- ☐ rectal pain
- ☐ nausea
- ☐ vomiting
- ☐ vomiting blood
- ☐ flatulence
- ☐ decreased frequency of BMs
- ☐ constipation
- ☐ increased frequency of BMs
- ☐ diarrhea
- ☐ fecal incontinence
- ☐ clay-colored stools
- ☐ greasy stools
- ☐ tarry stools
- ☐ blood in stool
- ☐ foul smelling stool
- ☐ other:

URINARY
- ☐ dysuria
- ☐ hematuria
- ☐ urinary hesitancy
- ☐ difficulty initiating urine stream
- ☐ difficulty maintaining urine stream
- ☐ urine dribbling
- ☐ increased urinary frequency
- ☐ decreased urinary frequency
- ☐ polyuria
- ☐ oliguria
- ☐ increased nighttime urination
- ☐ urge symptoms
- ☐ urinary incontinence
- ☐ urinary incontinence with cough
- ☐ other:

MUSCULOSKELETAL:
- ☐ muscle pain
- ☐ back pain
- ☐ tender points
- ☐ muscle cramps
- ☐ muscle weakness
- ☐ decreased muscle strength
- ☐ limb paralysis
- ☐ difficulty walking
- ☐ limp
- ☐ other:

DERMATOLOGIC
- ☐ dry hair
- ☐ brittle hair
- ☐ hair loss
- ☐ dry skin
- ☐ itching
- ☐ hives
- ☐ rash
- ☐ bruising
- ☐ new mole(s)
- ☐ skin sores
- ☐ skin lumps
- ☐ other:

BREAST
- ☐ breast lump (past or present)
- ☐ breast pain
- ☐ nipple discharge
- ☐ other:

NEUROLOGICAL
- ☐ headaches
- ☐ vertigo
- ☐ lightheadedness
- ☐ fainting
- ☐ blackout(s)
- ☐ numbness
- ☐ tingling
- ☐ tremor
- ☐ lack of coordination
- ☐ weakness
- ☐ difficulty speaking
- ☐ memory loss
- ☐ difficulty concentrating
- ☐ other:

PSYCHIATRIC
- ☐ change in mood
- ☐ depression
- ☐ sadness interfering with function
- ☐ anxiety
- ☐ nervousness
- ☐ sleep disturbance
- ☐ suicidal ideation
- ☐ hopelessness
- ☐ worthlessness
- ☐ delusions
- ☐ hallucinations
- ☐ other:

REVIEW OF SYSTEMS

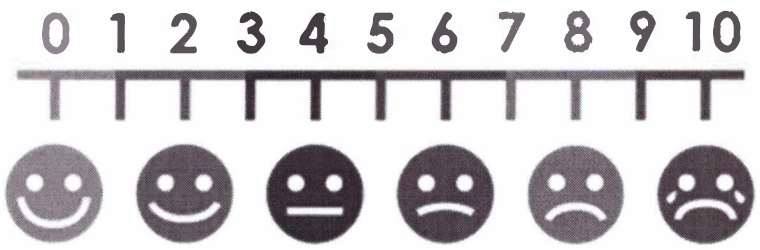
Patient's Name:	**DOB:**

In order to help us provide the best possible care for you, we ask for your cooperation in providing the following information.

Was this injury: ☐ At Work ☐ Auto Accident ☐ After Surgery ☐ Other
Onset of pain ☐ Sudden ☐ Gradual

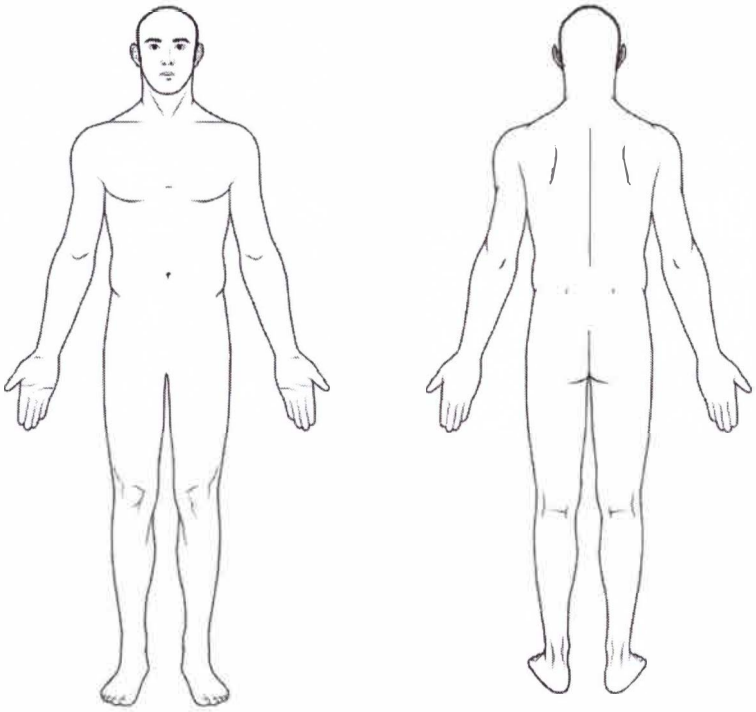
On a scale of 1-10, your pain is at its worst: _____ Pain at its best: _____ Pain right at this moment: _____

0 - no hurt
1-2 hurts a little bit
3-4 hurts a little more
5-6 hurts even more
7-8 hurts a whole lot
9-10 hurts the worst



LOCATION OF PAIN:

Indicate all areas of your pain on the human body outline



Associated with (check all that apply)

- ☐ Numbness/Tingling
- ☐ Night pain
- ☐ Weakness
- ☐ Loss of Control of Bowel
- ☐ Loss of Control of Bladder
- ☐ Fever/Chills
- ☐ Sexual Dysfunction
- ☐ Unexplained weight loss

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REVIEW OF SYSTEMS

Patient's Name:	DOB:

Please complete the following questionnaire to provide us information as to how your pain has affected your ability to manage in everyday life. ***Please answer every section****. Mark only* ***ONE*** *number in each section that is the most accurately described for you.*

Section 1 – Pain Intensity

- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 – Personal Care

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself, but it is very painful.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help, but can manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed, I was with difficulty and stay in bed.

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weight, but it gives me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on the table).
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than ¼ mile.
- ☐ Pain prevents me from walking more than 100 yards.
- ☐ I can walk only using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for more than 1 hour.
- ☐ Pain prevents me from sitting for more than ½ hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Section 6 – Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want, but it gives me extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 1/3 hour.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 – Sleeping

- ☐ My sleep is never disturbed by pain.
- ☐ My sleep is occasionally disturbed by the pain.
- ☐ Because of pain, I have less than 6 hours of sleep.
- ☐ Because of pain, I have less than 4 hours of sleep.
- ☐ Because of pain, I have less than 2 hours of sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

- ☐ My social life is normal and causes me no extra pain.
- ☐ My social life is normal, but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests.
- ☐ Pain has restricted my social life and I don't go out often
- ☐ Pain has restricted my social life to home.
- ☐ I have no social life because of pain.

Section 9 – Traveling

- ☐ I can travel anywhere without extra pain
- ☐ I can travel anywhere, but it gives me extra pain.
- ☐ Pain is bad, but I manage journeys over 2 hours.
- ☐ Pain restricts me to journeys of less than 1 hour.
- ☐ Pain prevents me from traveling except to receive treatment.

Medication List

Name:_____ **Date:**_____

Medication Name	Strength	Average# of pills each day	Why you take it